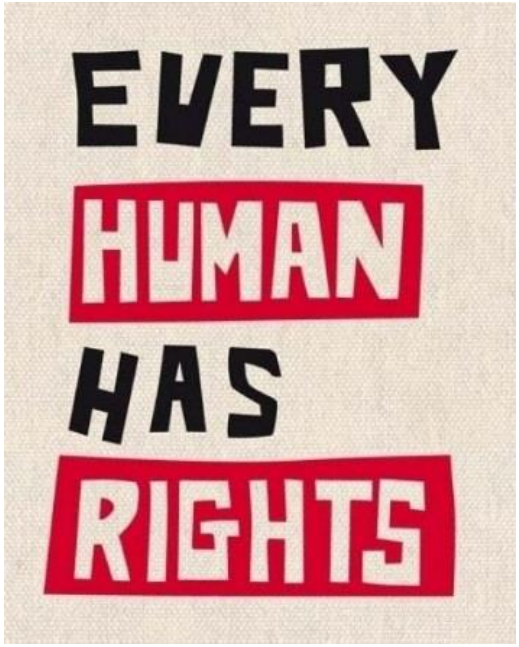
Hospital Based Human Rights Training



Presented by:
Department of Mental Health Licensing Division
April 24, 2023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Agenda

- Opening Remarks & Introductions
- Human Rights & Role of the Human Rights Officer (HRO)
- Overview of:
  - Incident Reporting
  - Complaint Process
  - Fact Findings
  - Administrative Resolutions
  - DMH Investigations
- Legal Rights & Status
- Q &A
- Closing

What are Human Rights…

Human Rights ensure that all people are treated as they would want to be treated--- as thinking, feeling, caring individuals.

- Department of Mental (DMH) identifies Human Rights with values and fundamental principles that support and promote respect, dignity, and care of each individual.

- The basis of DMH Human Rights can be found in:
  - Massachusetts General Law Chapter 123, Section 23
  - DMH Regulations 104 CMR 27.00 and 104 CMR 32.00

Human Rights include (but are not limited to...)

- Being treated with dignity and respect.
- Humane, person-centered care and treatment provided in a safe environment.
- Freedom from physical, sexual, verbal, and emotional abuse.

Person First Language

- At the heart of recovery-oriented psychiatric mental health care are the dignity and respect of each person and the ways in which helping professionals convey that they understand a person's uniqueness, strengths, abilities, and needs.

- **"Person-First Language" is a form of linguistic expression relying on words that reflect awareness, a sense of dignity, and positive attitudes about people with disabilities.**

- **As such, person-first language places emphasis on the person first rather than the disability (e.g., "person with schizophrenia" rather than "a schizophrenic").**

- **The use of person-first language is a foundation for recovery-oriented practice and enhanced collaborative treatment environments that foster respect, human dignity, and hope.**

Person-first Language - Mental Illness

1 AVOID SAYING	2 INSTEAD, SAY...
• Mentally ill • Lunatic • Psycho • Schizophrenic • Insane • Crazy • Bipolar	• "a person with (or impacted by) ____ [a confirmed mental health diagnosis] • "a person is ____" [disoriented, depressed, delusional, paranoid, hallucinating, etc.] • "a person in recovery from a/an ____ [a confirmed mental health diagnosis]

Person First Language...

Remember: a disability descriptor is simply a medical diagnosis

IN AN INPATIENT SETTING - THIS MEANS...

Encouraging a person to participate in their treatment and events in life - including the risks involved, as much as possible.

Fostering autonomy and positive self-regard.

Listening and accepting others' points of view.

Recovery Learning Communities

- Local consumer-operated centers that are in all DMH Areas.
- They rely on the momentum of the consumer movement.
  - self help/peer support
  - information and referral
  - advocacy and training activities
  - shifts the focus on symptom management to a focus on promoting recovery, resilience and wellness

Consistent with the person's individual needs, preferences, and capacities, the setting should offer:

- Freedom of Choice
- Least Restrictive Services
- Wellness Opportunities (per hospital policy)
- The opportunity to engage in person-centered treatment consistent with the person's individual desires

The Six Fundamental Rights for People of ALL Ages

1. The right to humane psychological and physical environment.
2. The right to receive visitors of their choosing daily and in private as reasonable and safe.
3. The right to receive or refuse visits and phone calls from attorney, legal advocate, physician, social worker, psychologist, or clergy.
4. The right to send and receive unopened, uncensored mail.
5. The right to reasonable access to a phone to make and receive confidential calls.
6. Reasonable Daily Access to Outdoors.

Reasonable Daily Access to Outdoors
104 CMR 27.13(6)(f)

In part, the DMH Regulations state:

- Patients shall have reasonable daily access to the outdoors (a space or area outside of a building, which may include a porch, courtyard, roof deck or open space surrounded by a building, and may be fenced, locked or otherwise secured), as weather conditions reasonably permit, in a manner consistent with the person's clinical condition and safety as determined by the treating clinician and with the ability of the facility to safely provide access.

- A facility can establish reasonable schedules or designated times for access to the outdoors, as long as each patient has a reasonable opportunity to access the outdoors on a daily basis.

- A facility is not required to provide access to the outdoors "on demand".

- No patient shall be compelled to participate in clinical programming as a condition of accessing the outdoors.

Reasonable Daily Access to Outdoors 104 CMR 27.13(6)(f) (continued)

- A decision made in accordance with 104 CMR 27.13(6)(f) to restrict a patient's access to the outdoors shall be reviewed daily by the treating clinician/designee to determine whether there is a change relative to the factors that resulted in the restriction. If such a determination is made, a new assessment shall be conducted. Such assessment shall be conducted within a reasonable period of time; provided however there shall be no requirement to provide more than one assessment in a 24-hour period. All assessments must be documented in the medical record.

- The facility should make provisions for altering the designated times for access in order to accommodate inclement weather.

- Access to the outdoors is a RIGHT and every attempt should be made to provide this time outside.

Reasonable Daily Access to Outdoors 104 CMR 27.13(6)(f) (continued)

- The facility shall have a written plan to implement its obligation to provide patients access to the outdoors, including procedures for secure and non-secure areas, reasonable capital expenditures, staffing patterns, and building access policies.
- If the facility determines that it cannot safely provide secure outdoor access due to staffing or physical plant limitations, it shall identify and document such limitations in the plan; and identify what actions it will take to address these limitations and the timeframe for the actions.
- Upon request of the Department, but no less frequently than in its application for licensure or license renewal, the facility shall demonstrate to the Department's satisfaction that its plan is current and that it has identified, considered and implemented all reasonable actions to safely provide access to outdoor space.

Authorized Restrictions

It may be necessary to **temporarily** limit someone's rights if there is good cause to believe there is significant risk of imminent, serious harm.

- Any restriction must be done in accordance with hospital policies.
- The record should include documentation of specific facts and the duration of the restriction, and the restriction must be reviewed and documented daily.
- DMH Regulations require that the Facility Director/ Designee makes this determination.
- The Human Rights Officer is to be notified of the restriction in a timely manner.

Dignity of Risk

Dignity of Risk is the principle of taking control of our lives- even when it includes some level of risk; this is the heart of the recovery process.

Treatment facilities should strive to foster as much education and person-centered planning and independence as possible to instill a proportionate sense of responsibility.

Only I
can change
my life.
No one
can do it for
me.

Carol Burnett

www.theerailivedin.com

So... What is the Role of the HRO?

The main responsibilities of the HRO are:

To assist, advocate for, and educate patients, families, and staff of patient rights, legal rights, and how to exercise them.

HROs should also review patient debriefings after restraint or seclusion and assist any patient who wishes to file a complaint.

Keeping the Language Alive

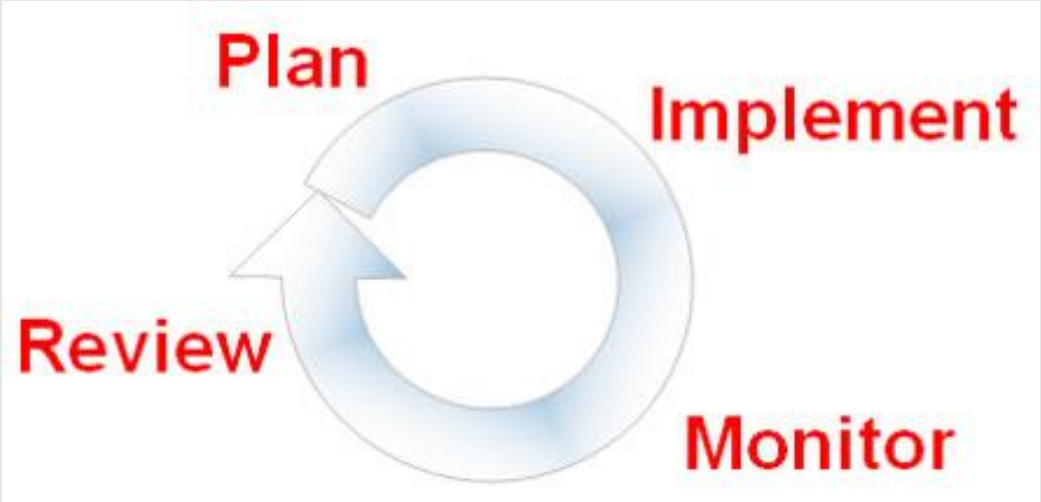
HROs (and staff) can ensure that Human Rights are at the forefront of everyday routines by:

Having the appropriate postings on the unit such as:

- Patients' Rights
- Complaint Forms are available
- How to access Interpretive Services
- How to exercise their Legal Right to Counsel
- Office Hours and Contact Information for the HRO and designee
- Restraint/ Seclusion Prevention Philosophy

Keeping the Language Alive

- The HRO having a presence on the unit to be available to patients, family members, and unit staff.



Keeping the Language Alive

Other examples of HRO involvement *may* include:

- Treatment Planning
- Policy Development
- Reviewing and contributing to the Patient Handbook
- Reviewing Investigations and DMH Decision Letters
- Participating in development of group programming
- Restraint/ Seclusion Prevention measures and episodes

Debriefing
After a Restraint or Seclusion Episode (R/S)

- The HRO is required to review every patient debriefing after a R/S, in a timely manner.
- The HRO may be a supportive presence to the patient (and treatment team) during the process.
- Any identified Rights violations require prompt follow up by HRO by meeting with the person, guardian, or authorized family member.

If it isn’t documented... It didn’t happen!

A log of all complaints and accompanying documentation should be kept for all complaints filed.

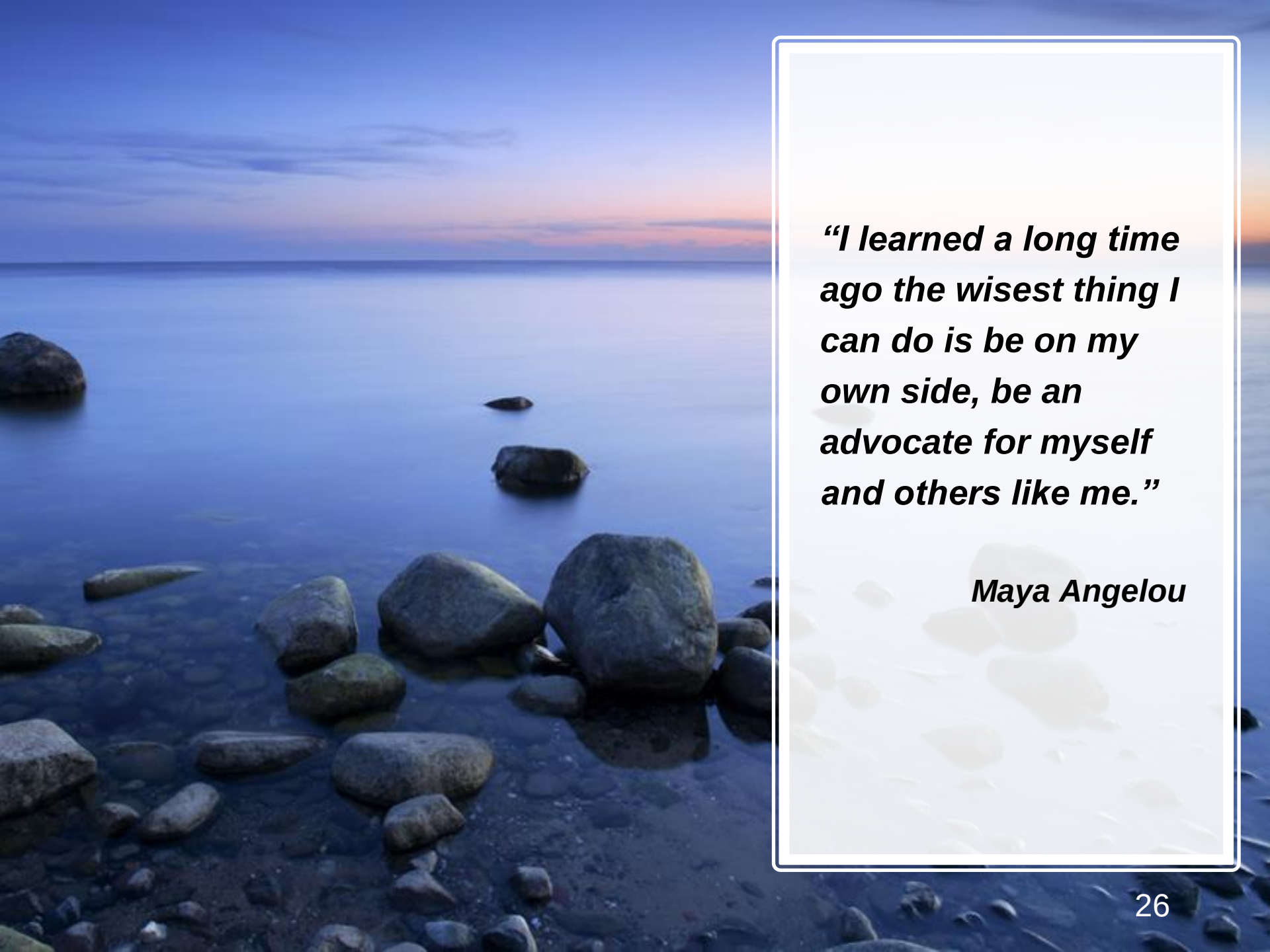
Complaints DO NOT have to be written - a verbal complaint needs to be addressed with the same attention and process.

This log should hold information regarding the patient’s name, nature of complaint, resolution, the patient’s understanding of the resolution, and if appeal rights were offered.

Remember

Things to Remember...

- Treat people with Dignity and Respect
- The Six Fundamental Rights should be in the forefront of all the language used in the handbooks and policies
- With Risk comes Responsibility and Reward
- HROs assist, advocate, and educate
- Be creative with how the HRO is involved on the unit



“I learned a long time ago the wisest thing I can do is be on my own side, be an advocate for myself and others like me.”

Maya Angelou

Who, When, Where, What, Why

All staff are responsible for protecting the people for whom they serve and for reporting anything **Dangerous, Illegal**, or **Inhumane.**

Incident Reporting, Complaints, and Investigations

- DMH Complaints and Investigations processes are governed by Massachusetts state regulation 104 CMR 32.00.

- The purpose of 104 CMR 32.00 is to establish a framework for the swift resolution of certain complaints and the reporting, investigation, and resolution of certain other complaints which are of a very serious nature or which have broad implications for persons receiving mental health services within the Commonwealth.

Incident Reports

An incident or condition that occurs either on the unit or within thirty (30) days of discharge which alleges…

1. medicolegal death;
2. sexual assault or abuse;
3. physical assault or abuse;
4. attempted suicide resulting in serious physical injury;
5. a felony has been committed;
6. restraint or seclusion practices not in accordance with DMH regulations which result in serious physical injuries; or
7. a sufficiently serious or complicated event or complaint as to require an investigation by the Office of Investigations...

…will be considered an incident**.** (104 CMR 32.04 (2)(a)(1-7)

All incidents need to be reported to the Licensing Division within 24 hours.
*****Not all Incidents are Complaints!*****

Additional Reporting Requirements From 104 CMR 27.03 (23)(h)

- Death, Serious Incident, Accident or Fire, Safety and Health Conditions. The facility shall verbally notify the Department immediately, and in writing within one business day, of the following:
  - upon learning of the death of any patient currently admitted to, or within 30 days of discharge from, the facility, regardless of where the death occurs;
  - any serious incident including, but not limited to, a complaint reportable pursuant to 104 CMR 32.04(2)(a), which occurs under facility auspices, or concerning any patient currently admitted to, or within 30 days of discharge from, the facility, regardless of location;
  - any fire or other event resulting in damage to the facility;
  - any alleged abuse or neglect, or sexual or serious physical assault, which occurs between or among patients at the facility, or which occurs between or among patients and staff regardless of location, including any incident which is reported to another agency or law enforcement including, but not limited to:
    - any reports of child abuse or neglect made under M.G.L. c. 119, § 51A;
    - any reports of elder abuse or neglect made under M.G.L. c. 19A, § 15; and
    - any reports of abuse of a disabled person made under M.G.L. c. 19C;

Additional Reporting Requirements From 104 CMR 27.03 (23)(h) (Continued)

- any condition at the facility which poses a threat to the health or safety of patients or staff; for example, conditions which limit access, unsanitary conditions, fire hazards, loss of essential services such as heat, hot water and electricity, regardless of whether the conditions cause an interruption of service. The facility shall consult with the Department to determine whether the condition requires an interruption or suspension of service;

- confirmed cases among staff or patients of communicable diseases which are reportable under 105 CMR 300.000: Reportable Diseases;

- and any complaint communicated to the facility by the Occupational Safety and Health Administration (OSHA) or the Commonwealth Division of Labor Standards (DLS), as well as any findings, citations, agreements or other notifications from OSHA or DLS in connection with such complaints.

Complaints may be filed with staff, the HRO, or the Person In Charge, and sometimes directly with DMH.
Complaints can be verbal or written and do not need to be on the DMH Complaint Form.

All Complaints are Reviewed to:

Determine if the complaint warrants an Administrative Resolution, a 10 Day Fact Finding, or an investigation by DMH Office of Investigations

Determine if immediate protective action should be instituted if patients or staff are thought to be in jeopardy

**** All Complaints require either an Administrative Resolution, a 10 Day Fact Finding Investigation by the hospital, or a full investigation by DMH.****

Administrative Resolution 104 CMR 32.04(3)

The complaint may be resolved administratively if it meets one of the following conditions;

1. Concerns an allegation of an incident or condition that is not dangerous, illegal, or inhumane;
2. Makes allegations that are objectively impossible;
3. Repeats allegations of fact that have been previously investigated and decided in accordance with 104 CMR 32.00;
4. Alleges a violation of regulation, policy, or procedure that does not present a health or safety risk to a client or other individual, and may be resolved or corrected without need for additional fact finding;
5. Is withdrawn by the client or complainant, provided the complaint does not concern the health or safety of a client or other individual; or
6. Presents undisputed facts which allow the Responsible Person to determine that the complaint can be best resolved through the administrative process.

Process for Administrative Resolution

In order to resolve a complaint administratively, the Responsible Person (in this case the Person in Charge/ Designee) must meet with the Client and the Complainant, if different, unless the Client and/or Complainant declines to meet with the Responsible Person, or despite reasonable efforts, cannot be located

1. The Responsible Person shall notify the Client and/or Complainant of the availability of the HRO to attend the meeting at the Client and/or Complainant's request.

2. Unless the Client and/or Complainant declines to meet or cannot be located, this meeting shall take place within 3 business days of the decision that the complaint can be resolved administratively.

3. The purpose of this meeting shall be to:
   a) review the specific allegations in the complaint;
   b) determine if there any disagreements that require further fact finding; and
   c) discuss and agree, if possible, upon actions, if any, that may be taken to resolve the complaint.

Process for Administrative Resolution (continued)

If the Responsible Person (Person in Charge or Designee) determines that the complaint cannot be resolved administratively, including disagreement regarding the facts, the complaint shall be referred for fact finding or investigation.

Upon resolution the Responsible Person shall notify the Client and/or Complainant, in writing, of;

1. the grounds for administrative resolution;
2. actions, if any, that will be taken by the Responsible Person;
3. the right to request reconsideration; and
4. the Client's right of appeal.

If during a 10 day fact finding, the Responsible Person determines that the criteria for administrative resolution are met, they may elect to stop the fact finding and proceed with administrative resolution.

10 Day Fact Finding Investigation (formerly "Below the Line")

Unless a complaint is resolved administratively, or is referred for a DMH Investigation, the Responsible Person (in this case the Person in Charge/ designee) must assign the matter for fact finding within two days. The fact finding must be completed within ten days from assignment unless the PIC authorizes an extension, in writing, of up to ten additional days.

The fact finder (this should not be the HRO) must:

1. Make reasonable efforts to interview the complainant and/or client (with a designated representative or HRO present if desired), and each person complained of;
2. Make a good faith effort to interview witnesses and others, including family members, who may have information related to the complaint;
3. Review all incident reports and other records related to the complaint, including the medical record, if applicable.
4. Provide a written report of findings of fact and recommended conclusions to the PIC.

10 Day Fact Finding (continued)

The Person in Charge (PIC) must:

- Issue a written decision within five days following completion of the fact finding.
- The written decision shall contain findings of fact and conclusions, and any actions to be taken.
- The decision shall notify parties (client/ legally authorized representative, complainant, persons complained of, HRO) of the right to request reconsideration and the client's right of appeal.
- If at any time during formal fact finding, it is determined that the criteria for administrative resolution are met, the fact finder may recommend in writing to the PIC that the matter be resolved as an administrative resolution.
- Files of all fact-finding activities are to be maintained with the PIC.

Complaints Investigated by DMH (formerly "Above the Line")

Upon receipt of a complaint, the Person in Charge shall determine if the complaint involves one of the following:

1. medicolegal death;
2. sexual assault or abuse;
3. physical assault or abuse which results in serious physical harm;
4. attempted suicide which results in serious physical harm;
5. commission of a felony;
6. serious physical injury resulting from restraint or seclusion practices; or
7. an incident that the Person in Charge in his or her discretion believes is sufficiently serious or complicated as to require investigation by the Office of Investigations or Director of Licensing even though it does not otherwise involve one of the categories listed in 104 CMR 32.04(2)(a)1. through 6.

DMH Investigations...

The Person In Charge is responsible to forward these complaints/ incidents to the DMH Licensing Division who will coordinate the investigation with the DMH Office of Investigations.

The investigation may include an interview with the complainant, the alleged victim, with those complained of, and other witnesses or family members involved. People who are to be interviewed are allowed to have another supportive person present, such as the Human Rights Officer, Risk Manager, or union representative.	The investigator will have thirty (30) days to conduct the interview and file written report with the Director of Licensing.	Upon receiving the investigation report, the Director of Licensing has ten (10) days to issue a decision letter to the complainant and the facility. This letter should be reviewed by the facility's Person In Charge (or designee), and HRO.

Appeal/Reconsideration of Findings

- A client, a client's Legally Authorized Representative, or an individual or entity authorized to act on behalf of a client or a client's estate may appeal decisions issued pursuant to 104 CMR 32.04(3) through (5) or (7)(a).

- In the case of a client's death, an appeal may be pursued or authorized by the duly appointed personal representative of the decedent's estate or other individual with legal authority to act on behalf of the decedent.

- All appeals must be in writing and filed within ten days of receipt of the applicable decision, which time period may be waived by the person responsible for deciding an appeal, upon request and for good cause shown. The person responsible for deciding an appeal shall forward a copy of the appeal to all other parties.

- Appeals shall be based on one or more of the following factors, which shall be set forth with specificity in the appeal:
  - The fact-finder failed to interview an essential witness or to consider an important fact or factor.
  - The decision is not reasonably supported by the facts.
  - The decision is based on an erroneous interpretation of applicable law or policy

Deputy Commissioner Level Appeal

A DMH client may appeal the Director of Licensing's decision to the DMH Deputy Commissioner for Clinical and Professional Services.

This decision shall be issued within thirty (30) days and will be final.

Some complaints may need to be reported to multiple agencies such as DCF, DPPC, or EOEA.

Department of Children and Families (DCF)

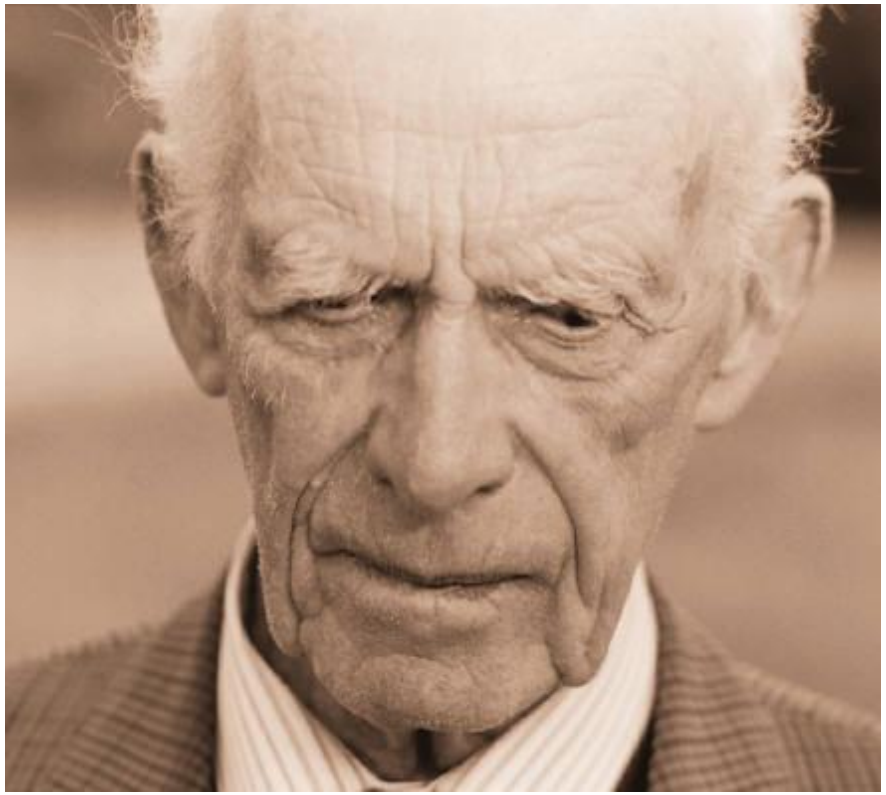
A DCF complaint (51A) is to be filed when you have reasonable suspicion of abuse or neglect of a child under the age of 18.

The complaint can be filed by phone: 1-800-792-5200

Disabled Persons Protection Commission (DPPC)

A DPPC complaint is to be filed when you have reasonable suspicion of abuse or neglect of a disabled person between the ages of 18-59 by a caretaker.

The complaint is filed by phone at 1-800-426-9009



Executive Office of Elder Affairs (EOEA)

An Elder Protective Services complaint is to be filed when you have reasonable suspicion of Abuse or neglect of an adult aged 60 or older.

The complaint can be filed by phone at:
1-800-922-2275

Informed Consent

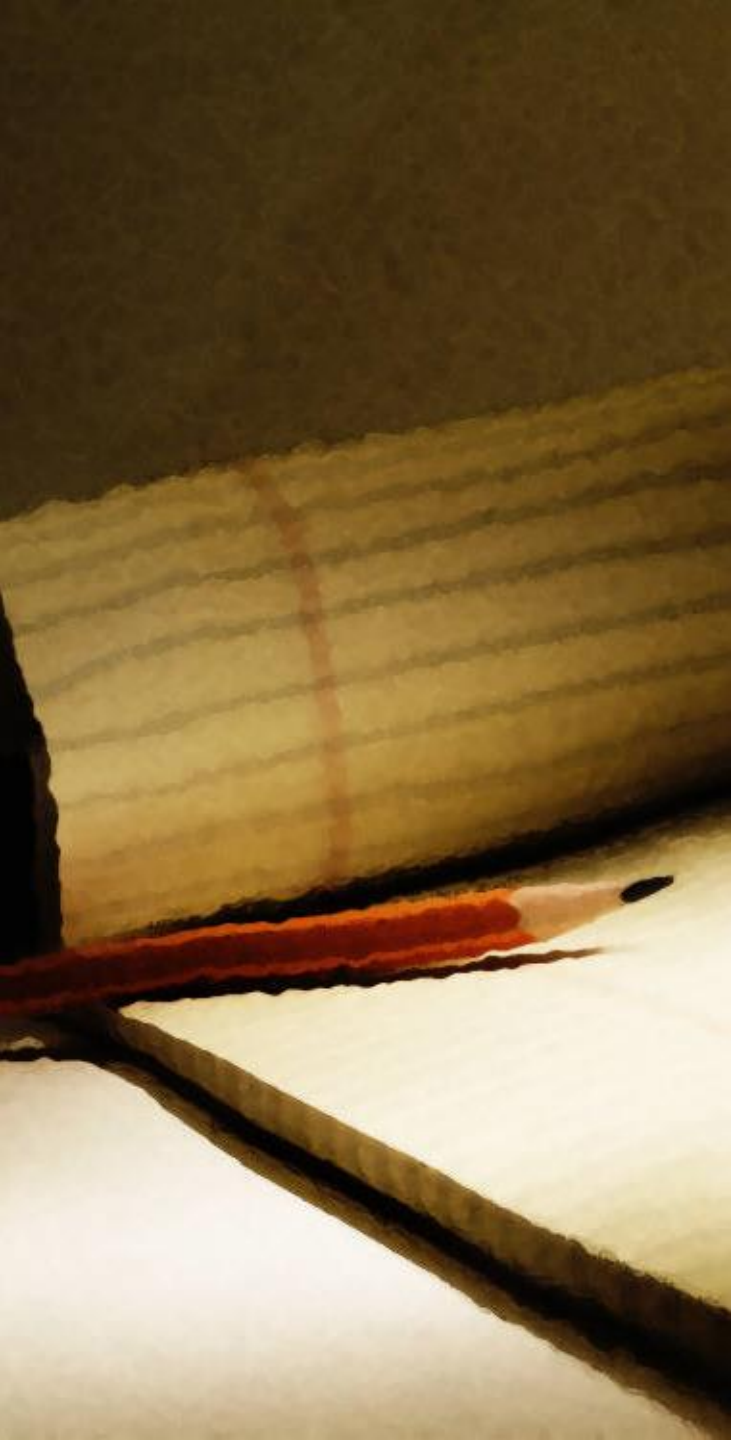
Informed Consent is based upon an informed decision...

- There needs to be an assessment of an individual's ability to understand the risks and benefits of a proposed treatment, including anti-psychotic medication, as well as alternatives (104 CMR 27.10).
- If the individual is not competent to make their own decisions and a Rogers Monitor or guardian is obtained, then this needs to be reviewed with him/ her.
- In an inpatient setting per DMH regulation, anti-psychotic medications, treatment purposes, side effects and alternatives to treatment must be reviewed with the patient, guardian, or Health Care Proxy (if invoked by physician) and documented by the prescribing clinician.
- An explanation of the right to withdraw one's consent to treatment, orally or in writing, at any time.

Legal Status

3 Day Involuntary Hospitalization- (§12b)

- Prior to admission on a 3-day involuntary hospitalization, the person must be given the opportunity to choose conditional voluntary status.
- If the person believes that the admission is the result of an abuse or misuse of the Section 12(b) admission process, a request for an emergency hearing can be made, to be held within 24 hours. A Conditional Voluntary should not be offered.
- If the physician or APRN determines the person has the capacity to understand the reason for hospitalization, the Conditional Voluntary is accepted.
- If the physician or APRN does not accept the Conditional Voluntary, the patient is admitted for a 3 day involuntary commitment.
- The Involuntary Status expires after 3 business days. The hospital must discharge the person at this time or petition for a § 7 & 8 Commitment.
- Hospital staff is required to assist the person, when requested, to contact the Committee for Public Counsel Services (CPCS) when a person is involuntarily hospitalized. (Calls can be placed 24 hours a day regardless of the time.)



Legal Status

Conditional Voluntary- § 10 & 11

- 3 Day Notice - A person may petition to leave after submitting or giving notice they want to leave. The notice does not have to be on any particular form, but staff must document in the record.

- The hospital has 3 business days (effective the next business day) after submission in which to discharge or petition the court for Commitment.

Legal Status

§ 7 & 8 Commitment

- If the hospital petitions for commitment, the person is required to stay at the hospital until a judge makes a decision to commit or discharge.

- A hearing will be conducted within 5 business days following petition.

Legal Advocacy Resources

Mental Health Legal Advisors Committee	Committee for Public Counsel Services (CPCS)	Disability Law Center
• (617) 338-2345 or • 1-800-342-9092	• (617) 988-8341 or • 1-800-882-2095	• (617) 723-8455 or • 1-800-872-9992


TIME FOR QUESTIONS

Licensing Contact Information

Janet Ross **Asst. Commissioner for CPS/Director of Licensing**	• Janet.Ross@mass.gov • 857-930-6828 (cell) • 617-626-8279
Sheila Lee **Director of Nursing for Licensing**	• Sheila.Lee@mass.gov • 857-383-9350 (cell) • 617-626-8119
Carey Lambert **Licensing Surveyor**	• Carey.Lambert@mass.gov • 617-564-8662 (cell) • 617-626-8110
Teresa Reynolds **Office Manager**	• Teresa.J.Reynolds@mass.gov • 617-626-8117 • Confidential Fax 617-626-8167

References

Massachusetts General Law Chapter 123, Section 23

DMH Regulations 104 CMR 27.00, and 104 CMR 32.00

DMH Policy #03-1

DMH Human Rights Handbook

DMH PACE Training for Human Rights

Mental Health Legal Advisors Committee

Sage Journals- http://jap.sagepub.com/content/193146.short

The jjslist Blog- http://www.jjslist.com/blog/person-first-language-101?gclid=CMDRsL7k0csCFdgOgQod7HQNKA

Kathie's People First Language- http://www.inclusionproject.org/nip_userfiles/file/People%20First%20Chart.pdf


thank you!